Southern Humboldt Community Healthcare District
Confidential Financial Assistance Application

Patient Name	Date of service	MR# or account number

RESPONSIBLE PARTY

Name			Marital Status	Social Security Number
Street Address, City, State, Zip			How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)				Business Phone
Position / Title	Monthly Income – Gross	Monthly Income – Net		Length of Current Employment

SPOUSE

Name			Social Security Number
Employer Name and Address			Business Phone
Position/Title	Monthly Income – Gross	Monthly Income – Net	Length of Current Employment

DEPENDENTS

Name & Year of Birth of all persons in household	Total Number of Persons in Household	Do Any Other Persons Contribute? Yes/No	If Yes, Amount: Amount

INCOME PER MONTH & ASSETS

Dividends, Interest	$	**Child Support/Alimony**	$
Public Assistance/Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		$

EXPENSES PER MONTH

Mortgage/Rent	$ Balance: $	Medical/Dental	$
Own Home? (Yes/No)		Doctor – Name	
Food	$	Doctor – Name	$
Utilities:		Doctor – Name	$
Electric	$	Credit Cards:	$
Gas	$	Visa Limit	$
Water / Sewer	$	MasterCard Limit	$
Trash	$	Discover Limit	$
Phone	$	Other Limit	$
Cable	$	Installment Loans	$
Auto Payments	$	Child Support	$
Auto Expenses	$	Miscellaneous Expenses	$
Insurance:	$		$
Auto Premium	$		$
Life Insurance	$		$
Health Insurance	$		$

OFFICE USE ONLY Gross income___________________________ Net income_____________________________ Total Expenses__________________________ Total Net income(loss)____________________	To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing. ***PATIENT/GUARANTOR SIGNATURE DATE***